

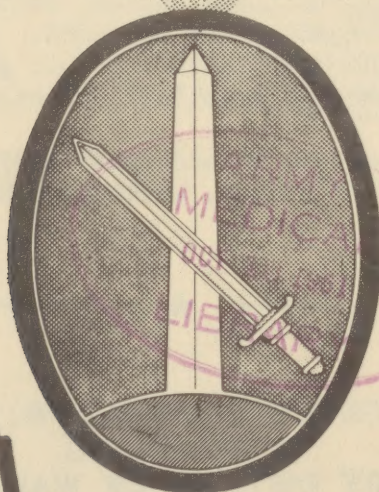
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RESTRICTED

MONTHLY HEALTH REPORT

Military District of Washington



RESTRICTED

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This "Monthly Health Bulletin" invites every reader to participate in its preparation by contributing articles. There must be something in the daily military experiences that will interest others and possibly be helpful to others. Administrative directives, professional articles, clinical notes, descriptions of new devices and instruments are welcomed. While the number of copies of this publication is not great, there is a wide distribution, geographically speaking.

Contributions should be addressed to The Surgeon, MDW, Room 2D-201, The Pentagon, Washington 25, D. C.



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INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

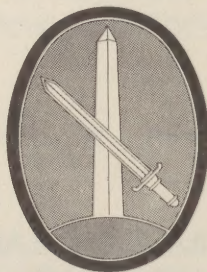
It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as a basis for requisitioning supplies or equipment.

Contributions; as well as suggested topics for discussion, are solicited from Army Medical Service personnel in the field.

ROBERT E. BITNER
Colonel, MC
Surgeon

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MEDICAL EVALUATION OF THE NON-EFFECTIVE SOLDIER

By

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The purpose of this article is to clarify the function of the medical officer in the management and disposition of the non-effective soldier. Noneffectiveness as defined herein is restricted to individuals without physical and mental disease but who demonstrate inadequate duty performance. More specifically, this communication refers not to disabled soldiers, but to individuals who either by virtue of poor attitude and motivation or personality disorders, are a disciplinary problem or a handicap to their organization. Non-effectiveness is usually manifested by either symptomatology (such as backache, headache and fatigueability), or disciplinary difficulties (which include alcoholism and drug addiction).

While most disciplinary infractions are handled by direct administrative action, it is common practice to refer less overt instances of non-effectiveness to unit medical officers and military hospitals. This occurs because of the quandary of the line officer who feels insecure in dealing with soldiers who may belong in the realm of mental and physical disease. There exists also the unconscious and sometimes conscious desire of unit commanders for medical evacuation to rid them of vexing problems and thereby avoid the more difficult and time-consuming administrative procedures. Frequently, the medical officer is aware of the problems of the line officer and is in sympathy with his dilemma. The indefinite boundary between symptoms and disease may be utilized by both line and medical officers as a basis for medical evacuation. They argue convincingly to themselves that the individual very probably has something wrong with him and anyway, he is of no value to the outfit. This line of reasoning is even more true where the field of mental abnormalities is concerned. The unit commander can easily rationalize that the alcoholic, the drug addict and the aggressive disciplinary offender must have some kind of mental illness, otherwise he would not act in such an abnormal manner. Regardless of motives, the line officer does need medical support to help him arrive at a medical solution in the disposition of the ineffective soldier. In order to properly render such support, it is necessary that medical officers become familiar with the mechanisms and causes of non-effectiveness in the military service.

Non-effectiveness represents a failure of adjustment to a given situation. Man cannot remain static but must have the ability to alter his methods of obtaining gratification and his goals in accordance with the realities of a changing environment. The degree of adjustability among individuals varies considerably; there are persons who can adjust in only a limited manner under specified conditions. For example, a soldier may be effective only at a certain type of work when stationed near San Antonio, Texas, where he can see his wife and mother daily. Others have the ability to sustain themselves in an effective manner in the stressful environment of severe combat. Again there are individuals with severe personality defects who cannot adjust under any circumstances and exhibit a life-long pattern of repeated failures.

To consider only the role of the individual is insufficient to explain fully the struggle involved in adaptation. One must take into account the nature and severity of the various external stresses imposed upon the person in order to appreciate that adjustment is the end result of an interaction between a particular personality and specific environmental forces. The exigencies of military service place a strain on the adjustment resources of the soldier. A civilian can find a niche for himself and maintain a relatively constant environment. The soldier must be prepared and able to function efficiently under conditions which vary from frequent changes of unit commanders, overseas separation from his loved ones, and the uncomfortable and hazardous life of combat.

Another pertinent environmental factor is the motivation of the military unit. It is usual for soldiers to identify with others in their group. The newcomer soon assumes the ideals and attitudes of this organization. Units with poor morale do not require effective performance by the individual and do not support each other in times of stress. Organizations with high morale insist on efficient standards of duty and in this way sustain each other in overcoming adversity. Leadership is the most important single factor in the production and maintenance of unit morale. The officer who is ineffective as demonstrated by his overt insecurity or unfair and neglectful treatment of his men, adds further stress to the already difficult milieu of the soldier. The good leader supports the soldier and enables him to initiate and maintain effectiveness under severe adverse circumstances.

The basis for medical recommendations in the management and disposition of the non-effective soldier can be best demonstrated by considering the usual problems encountered by individuals of various personality types. The following division of individuals into separate groups should not be taken in a finite sense but for descriptive purposes corresponds to the relative degree of personality dysfunction:

THE AVERAGE SOLDIER: The average soldier has a relatively stable personality and can adjust effectively even under severe stress when he is in a unit with good morale. There may be occasions when he becomes temporarily disorganized but his adjustment faculties are sufficiently elastic for him to resume his previous adaptability promptly. Good leadership facilitates this adjustment process.

More pertinent are the avoidable circumstances which may produce non-effective behavior and performance even by the average soldier. Such difficulties are usually the result of faulty functioning of command and range from unfair treatment by the unit commander to the malassignment of individuals to positions for which they are unsuited from the standpoint of training and intellectual endowment. The resultant ineffectiveness may be exhibited in the form of unwillingness, mild disciplinary infractions, and vague symptoms such as headache, tension and insomnia. Under such continued adverse circumstances, the individual loses his ability to feel as one with the group and blocks his inner insistence to conform, since he feels he is being treated unjustly.

This state of affairs can be recognized by the medical officer because of good performance record even under adverse conditions prior to his current difficulties. The medical officer must be cautious in evaluating the administrative complaints of soldiers, yet unmistakable evidence of mismanagement is usually elicited from the often dispirited, mildly hostile, and depressed soldier. It is important for the medical officer to communicate his findings to the unit commander outlining the causative factors and recommending that remedial action by him is indicated. It is not necessary or even desirable to state specifically the type of remedial action. This falls more properly within the province of the line officer.

THE UNWILLING SOLDIER: The unwilling soldier is a poorly motivated individual who can perform effectively only by virtue of outside insistence. This type of individual is intolerant to the attendant discomfort experienced by everyone when forced to make an adjustment under conditions which are disagreeable. He is easily influenced by gripes and rationalizations which convince him that his situation is intolerable. Essentially he is a selfish person who can see no reason for enduring hardship when there is no personal gain involved. Such a feeling is present in all of us, but in the average soldier there is an insistent inner demand and self-pride which forces him into a spirit of cooperation. The unwilling soldier lacks this inner demand to conform. It follows that

external pressure must be substituted in order to make him perform adequately. The unwilling soldier often presents himself as being unable to perform duty because of physical complaints. The medical officer can arrive at a proper evaluation after a reasonable physical examination, a history of over elaboration of external difficulties, common to all, and a background which indicates previous attempts to avoid onerous tasks. The recommendations of the medical officer should include the diagnosis of no diseases, poor attitude and motivation, with the information that the individual has the capacity to perform adequate duty. The line officer is then free to apply remedial measures and to feel secure that he is not doing an injustice to the individual.

THE IMMATURE SOLDIER: The immature soldier is characterized by a retarded emotional development which is not commensurate with chronological age and physical growth. The result is an individual who exhibits ineffectual, childish, or adolescent behavior when exposed to slight or moderate environmental stress. Almost anyone may temporarily demonstrate immature behavior under the impact of severe external pressure. The immature person with a limited capacity for adjustment is more readily influenced by fluctuations in the environment; in effect, he is as if internally crippled and therefore unable to alter and sustain himself under varying circumstances. Basically, the personality defect lies in the inability of the immature individual to either mobilize or adequately discharge aggression when such an adaptation is necessary for effective action.

There are various types of immaturity reactions, dependent mainly on the manner in which aggressive impulses are manifested. Perhaps the most common variety is the passive dependent personality. This type of person is illustrated by the timid, passive, fearful soldier who seldom fires his rifle at the enemy; faints at the sight of blood; shies away from physical fights and even verbal arguments, and is readily rendered helpless when under dangerous stimuli. Here we see clearly the effects of almost complete inhibition of aggressive drives, usually, the result of severe intimidation during the early formative years of life. The passive dependent person is rarely a disciplinary problem and often gives effective performance in garrison duty or in a protected overseas assignment. He may have an excellent military record prior to the current stressful situation. Depending on the degree of passivity in the character make-up, many of this immaturity type can be helped to a more aggressive adaptation by such measures as training, with a consequent increase of confidence in himself and his weapons; group identification, which gives emotional support to lessen his inner feelings of insecurity and makes it possible for him to assume the aggressive attitude of the unit; and individual guidance by NCO's and officers who by advice and example demonstrate a more logical approach to danger than trembling and helpless inaction. Individuals with a severe personality difficulty of this type may only be able to perform noncombat duty.

The next common type of immaturity is the passive aggressive individual. He is also conspicuous by the absence of outward manifestations of aggressiveness but demonstrates some degree of hostility in the form of stubbornness, procrastination, and obstructionism. This type of person may appear resentful but denies such feelings, usually stating that he cannot work because of headache or backache. He denies to himself feelings of insecurity and finds superficial rationalizations for his ineffective performance under stress. The passive aggressive soldier may also have had a previous good record when under minimal stress. He is different from the unwilling soldier in that there is an absence of words or actual acts of aggression. This points to the real defect in the personality and indicates that any evaluation and recommended corrective measures must be oriented along the lines of overcoming excessive insecurity by support and training as outlined under the passive dependent type.

Least common is the aggressive personality. These individuals are quite tense when under stress because of marked insecurity. Uncoordinated and ineffective aggressive outbursts may result from the consequent accumulation of tension. These explosive outbreaks are seldom directed against the enemy but usually occur against a friendly and safe environment. It is similar to the temper tantrum of childhood which may be effective at that age in gaining an objective but is far from an adult adjustment. Here again evaluation and management must be based on the degree of severity of the personality defect and similar measures are indicated to help the individual overcome his underlying excessive insecurity.

A special form of immaturity is that exhibited by individuals with enuresis. This may be combined with other manifestations of immaturity or exist as a single phenomenon. Essentially, enuresis is an infantile or childish manifestation of hostility which recurs in adult life when external danger makes it difficult if not impossible for them to utilize later acquired aggressive adaptations. It is common for the enuretic to give a history of bed-wetting often up to 13 or 14 years of age after which there is a spontaneous cessation with recurrences at various stressful times in their adolescent and adult years. This archaic mechanism of hostility is usually unconscious to the person. Threats and coercive action rarely have any corrective value. The important principle of how effective the individual functions even with this habit should be the criterion for reassignment or release from service under 615-369. Enuretic soldiers in combat have a difficult problem because it is impossible to change clothing. Individuals in rear and support units where laundry service and washing facilities are readily available can often continue rendering adequate duty, particularly since the enuretic habit may be less frequent when the environment is more secure. Discharge from the service should be considered when enuresis is combined with other manifestations of a severe degree of personality disorder.

THE ABNORMAL SOLDIER: The abnormal soldier or the pathological personality has such severe defects or distortions of character that he represents the largest deviations of behavior from the average soldier. This type of person is usually incapable of consistent effective adjustment even under favorable conditions. The environment plays a negligible role in the adjustment process because the basic difficulty is inherent in the individual who is unable to obtain gratification of his needs except by means and methods considered abnormal or frowned upon by society. Included in the pathological personalities are antisocial individuals, asocial or the criminal group, the withdrawn or schizoid personality, the drifters or inadequate personalities, the narcotic and alcohol addict, and sexual deviates. It is evident that while abnormal soldiers have in common pathological personality traits, it would be an error to consider them a homogenous group. They are rather a mixture of several dissimilar smaller groups, each one having its characteristic internal disharmony and external manifestations. A brief description of the various types of pathological personalities follows:

The antisocial personality: This soldier is characterized by repeated but relatively minor disciplinary episodes. He rarely commits a major offense such as desertion or murder. Alcohol excesses on and off duty are common. His life pattern is replete with similar antisocial events, none of which have merited a long prison sentence. He is restless and cannot be satisfied by the usual pleasurable methods. He is unable to feel the loyalty to a person, group or code. It is characteristic for him not to profit by experience or punishment as he seemingly does not possess the inner motivating force of conscience. Often he is quite mentally agile and appeals to the unwary to give him another chance. For brief periods of time, he can do even superior work and may in this manner continue on in military life because of his ability to convince others that he will do better in the future. When in disciplinary difficulty, he pleads amnesia or physical illness in an effort to enlist the aid of the medical officer. He is well known to the psychiatrist as "a psychopath" and valiant efforts by expert therapists usually result in failure.

The asocial personality: This is the individual who completely disregards the moral code. He constitutes the hardened criminal type and is commonly seen in penal institutions. Rarely does he voluntarily enter military service and usually makes every effort to avoid induction by the draft. As a result, this type of abnormal soldier is seldom encountered by the medical officer unless for mental evaluation prior to general court-martial.

The schizoid personality: This is an odd individual, eccentric and exclusive, who lives in a small world of his own and is disturbed by association with others. He compensates for human companionship by day dreams and fantasies. Others soon learn to leave him alone when their overtures are passively rebuffed. He is the most effective of the pathological personalities as often he can perform consistent, useful duty if not bothered, or placed in a solitary technical position. He becomes a problem when dislocated from his narrow environment. Once disturbed, it is difficult for him to regain his previous adjustment. At best such individuals can be utilized in only a selective limited manner because their capacity for adjustment is minimal.

The inadequate personality: This is a rather well-known abnormal soldier who is conspicuous by his failure to respond adequately to the physical, emotional and mental demands of the environment. Like an infant, he is helpless and usually gives a variety of bodily complaints to explain his shortcomings. He has a life-long pattern of inadequate performance, although in civilian life he may have made a marginal adjustment in a menial or part-time job. He is a drifter as he moves from place to place and from job to job in a vain effort to find someone who will take care of him. Frequently he voluntarily enters military service in the hope that he will be provided with the necessities of life with few demands upon him. If married, there is a helpless dependency on his wife. He is seemingly only effective in the production of offspring. Inevitably, this type of individual has an Army record of being tried on every type of work in his unit. He is seldom a disciplinary problem except in a minor way from alcohol excess or being late to work. Usually he is not hostile as he protests repeatedly that he has chronic back trouble or a persistent stomach disorder which he justifies by a long history of repeated hospitalizations and medication to confirm his story.

The alcohol addict: The alcohol addict must be differentiated from the temporary alcohol excesses of the average, the unwilling and the immature soldier. In effect, alcohol for the addict is a way of life. He can point to no actual frustrating or situational difficulty. His defect lies in an inability to lead an average existence and to be gratified by the usual objects in his environment. Like an infant, he is only satisfied and happy when he has a bottle in his mouth and when his stomach is full. He may do excellent work for periods of time which in his younger days may have been as long as one year. As he becomes older, his attempts to gain pleasure from the usual environmental sources become less and less effective. Not infrequently, he may give the appearance of a genial, generous and friendly person. When intoxicated, he pleads for sympathy and willingly agrees to any type of treatment, this is only temporary and passes when the need for alcohol again occurs. He vexes his family and friends and infuriates his military superiors as he habitually fails to fulfill his solemn promises of remaining sober. Popular science publications have given the impression that alcohol addiction is a disease. This is readily seized upon by the unit commander who is desperately trying to transfer or otherwise dispose of the problem, and the addict who always pleads for another chance when he is involved in a disciplinary difficulty. Both want the medical officer to be responsible for different reasons. In truth, alcohol addiction is not a disease but the individual's way of treating himself, of substituting the bliss of intoxication for the onerous and often boring details of daily existence. Treatment of this maltreatment is repeatedly demonstrated to be doomed to failure. Treatment of the underlying character defect is seldom desired by the addict. The only effective treatment thus far is Alcoholics Anonymous which substitutes another way of life for the addict. In this connection it is interesting that this regime is only effective if the addict maintains an active participation in the group. When he becomes inactive or disinterested, he returns again to the alcoholic way of life. It should be realized that the problem of alcoholism is a large one for the entire country. Constant efforts are being made to improve our knowledge and management of the causes and effects of alcoholism. The opinions stated above represent only a small aspect of the problem which affects military efficiency.

The narcotic addict: What has been stated under "alcohol addiction" applies to narcotic addiction except in a more severe degree. The narcotic addict is not infrequent in this command because of the low cost and easy access to opiate drugs in certain areas of Japan and Korea. The narcotic addict is even a weaker individual than the alcohol addict in his inability to tolerate the usual discomfort of even garrison existence. He uses opium derivatives which have a more devastating effect upon the body than alcohol. The physical craving for the drug may be so strong that he will abandon his ethical code and stoop to any act to obtain the drug. He is a particular menace in military life since he is prone to initiate young and susceptible soldiers in the path of addiction. Treatment is mainly unsuccessful unless rigidly controlled by incarceration for long periods of time. Such a regime may salvage the beginner in addiction, but rarely if ever changes the confirmed addict.

The sexual deviate: This abnormal soldier does not obtain sexual gratification by the various usual methods but finds it necessary to practice perversion of some type. In the vast majority of cases this consists of a desire for an individual of the same sex. The sexual deviate is an unfortunate and usually unhappy person who presents an age-old problem, the cause of which has its roots in the early formative years of childhood. It should be noted that the medical officer may be unable to arrive at a diagnosis in many of the cases referred to him because objective signs are not present and the history as given by the subject may be unreliable. Suspicion by others and effeminate mannerisms do not warrant a conclusion which may be unjust. In general, the service of the abnormal soldier is unsatisfactory and undesirable. Current AR 600-443 provides administrative methods of discharge from the service.

Disposition of the abnormal soldier: The abnormal soldier presents a difficult management and disposition problem. He is not psychotic from the clinical standpoint and is not insane in the legal sense. While he does have severe and unconscious intrapsychic pathology, he is only distressed or uncomfortable when blocked by outside sources from gratifying his desires. Therefore he is not considered to have a mental illness, although there is undoubted psychopathology. Rarely can he be salvaged or altered by psychiatric treatment even by the most expert clinical facilities. Coercion, threats, punishment, pleas and exhortations have little permanent effect. Imprisonment may satisfy the needs and demands of society but serves to intensify the internal difficulties of the pathological personality and may occasionally cause a transient psychotic outburst. Years of experience with the abnormal soldier has taught the military that, as a rule, it is unprofitable to continue his service. He is considered to have habits and traits of character undesirable for military service and administrative channels for his separation are provided under AR 615-368. It is interesting to note that civilian authorities have had no better success than the Armed Forces in salvaging or altering the pathological personality. However, in civilian life abnormal individuals have less restrictions which allows them to continue their non-effective and abnormal behavior relatively unnoticed except when their activities are of a criminal type.

SUMMARY: This article is concerned with the function and responsibility of the medical officer in the matter of ineffective soldiers who are not disabled by physical or mental disease. The basic causes and mechanisms of the various types of non-effective individuals are outlined. It is reiterated that the medical officer is required to give support in the form of recommendations to the line officer for handling and disposition of such referred individuals. The medical officer is not responsible for the accomplishing of remedial or administrative action and should not utilize medical facilities for the removal and disposition of the non-effective soldiers.

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PROFESSIONAL SERVICES

MEDICAL TREATMENT OF BURN CASES

A burn study project was established approximately two years ago at the Surgical Research Unit, Brooke Army Hospital, Brooke Army Medical Center, Fort Sam Houston, Texas. It is expected that this project will be continued and expanded if adequate numbers of cases are available for study. Cases suitable for study are considered to be those severe burns in excess of 10 percent of body surface involvement. The facilities available at Brooke Army Hospital for the treatment and study of these cases are outstanding.

Accordingly, severe burn cases may be transferred to Brooke Army Hospital for observation, treatment and study when it is determined that they are transportable and are appropriate cases for treatment at that hospital. In the interest of expeditious movement of these patients, direct communication with the Commanding General, Brooke Army Medical Center is authorized to determine availability of a bed and whether the case is appropriate for transfer. After concurrence for transfer has been given by the Commanding General, Brooke Army Medical Center, transfer may be made as an emergency case, without prior authority from the Armed Services Medical Regulating Office. The Armed Services Medical Regulating Office will be advised of action taken by the transferring hospital in all such cases. A special research team at the Surgical Research Unit, Brooke Army Hospital, is available for dispatch to any hospital in the United States to aid in the early treatment of burn cases, and to advise hospital commanders on the transportability of such cases. To obtain this team, hospital commanders should telephone or telegraph the Commanding General, Brooke Army Medical Center, ATTENTION: Director, Surgical Research Unit. In order to provide for proper selection of cases for research and to make available to aid of highly qualified personnel of the research group, the Director, Surgical Research Unit should be advised of the admission to any Zone of Interior Army hospital of all severe burn cases at the earliest practicable date. The importance of early notification cannot be emphasized too strongly.

Each case will be considered on an individual basis with the welfare of the patient being the basic consideration as determined by sound professional judgment.

(The above article is from SGO Circular No. 148, dated 5 September 1951)

* * * * *

NEW DRUG BEING TESTED BY ARMY MAY PROVIDE RAPID CURE FOR MALARIA

A rapid cure for malaria may be provided by a new drug, primaquine, available at the present time only for experimental use, and now being tested extensively in the field. Tests already conducted indicate that primaquine may be a far more effective treatment for malaria than any other drug now in use, according to Major General George E. Armstrong, Army Surgeon General. He emphasized, that further research is necessary to determine whether it will prove as effective against the strain of malaria found in Korea as it has against experimental strains. If field tests of the drug prove satisfactory, its use should greatly accelerate the recovery of military personnel returning from Korea who have contracted malaria in that country.

Initial work with the drug, conducted among prisoner volunteers at the Statesville Penitentiary, Joliet, Illinois, in cooperation with the University of Chicago, revealed a high percentage of cures among malaria cases with no subsequent relapses. After later tests by the Army in Nicaragua, experimental programs were recently established at Army hospitals in the United States, to determine the effectiveness of primaquine among returned Korean patients. Early results have been favorable.

General Armstrong emphasized that the successful standardization of primaquine will have no effect on the importance of chloroquine as a malaria suppressant.

(The above article is from Technical Information Office, Office of the Surgeon General, Department of the Army, Washington 25, D. C.)

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PSYCHIATRIC FEEDING

Paper aids in solving problems in feeding disturbed patients.

Every psychiatric nurse has had the unpleasant experience of having a mentally disturbed patient throw food in her face or try to crash a plate over her head. The destructively inclined patient may also hurl dishes, glasses, silverware or food at other patients. And those with suicidal tendencies are apt to try to utilize their eating utensils as instruments of self-destruction.

Since feeding presents in every respect special problems different from feeding of more normal patients, psychiatric nurses and doctors rightly give a good deal of attention to desirable techniques.

An increasing number of neuropsychiatric institutions, as well as general hospitals which have psychiatric beds, have been installing part-paper or all-paper food and drink service for their disturbed patients.

In the 110-bed psychiatric ward of Manhattan's huge and famous New York Hospital (second oldest hospital in the country), for instance, disturbed patients are served entirely in paper cups, paper containers and paper plates.

The handsome skyscraper Wesley Memorial Hospital in Chicago, a general hospital with 619 beds, has all its neuropsychiatric patients on almost 100 per cent paper service. Hot and cold drink cups are used for all liquids and beverages, including in-between-meal nourishments, while paper food containers carry servings of vegetables, salads, and sauces and condiments of the patient's tray. Only the entree and dessert are served in china, and if the patient is overwrought he gets paper for these.

The 125-bed Langley Porter Clinic in San Francisco, a mental institution, uses paper cups exclusively for drinking purposes on the wards where they are kept in dispensers. "Disturbed patients may pull down half a dozen cups for one drink of water," one of the staff says. "But even with this amount of waste, we think that paper is the only safe type of container to have in the wards."

Doctors and nurses in psychiatric work disagree on the ideal method of food service to the mentally ill. Controversy exists over whether it is more desirable to maintain, as far as possible, an appearance of familiarity in the environment at any cost; or whether the paramount concern should be rather to guard the aggressively active patient from his own violence, and to protect those attending him.

The first school of thought favors china or plastic eating utensils. In one of the leading private institutions following this line, the patients were given china and glassware at meals and permitted to break them if they were so inclined. This institution is heavily staffed--more than two staff members to each patient--so a maximum amount of personal supervision is possible. During World War II, however, the breakage of china became expensive, and a shortage of personnel lessened the amount of attendance possible per patient. Paper containers were substituted for soups and beverages, and paper plates were used for the main course.

The second school of thought--that protection of the patient is paramount--is fostering the trend toward more paper service for the acutely ill psychotic. These institutions, while recognizing the desirability of creating the proper psychotherapeutic environment, also admit that as long as a patient is disturbed, he cannot be safely kept in normal surroundings.

Rooms or wards of acutely disturbed patients must usually be stripped of everything except the barest furniture; mirrors, for instance, are usually omitted from the furnishings. It is part of the patient's further protection, therefore, the reasoning runs, to keep anything sharp or breakable in eating utensils away from him as long as he is in the excited state. Once returned to a quieter condition, he may be gradually reintegrated into the activities of the normal world.

The issue of any case, as one expert points out, resolves itself into the question: how much of the equipment of the normal environment can a patient be safely allowed to handle at a particular phase of his illness. The answer must depend in part on the good judgment of the attending doctor,

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who should be able to decide when there are risks. The answer also depends on the protection of staff to patient load.

If the patient can be constantly attended, danger from self-injury is less. Suicidal patients may even eat in small groups in dining rooms, under careful surveillance. But in the larger hospitals where the psychiatric wards may contain many beds, shortages of personnel often make it impossible to maintain constant vigilance. An aggressively active patient can create general panic and render injuries to himself and others if he has access to anything breakable.

All psychiatric nurses agree that any method of feeding the patient which will establish pleasant associations is desirable. Food service should be as attractive as possible. The crisp, fresh look of an all-paper tray can be as appetizing to the jaundiced eye of a mental patient as any other. And paper cups and containers for food and drink may also aid the nurse if the patient suffers from delusions about the purity of food.

Patients who believe they may contaminate others if they eat from common utensils, for instance, will often eat if served on single-service disposable paper. If they believe they are being poisoned, they may be tempted if food such as potatoes, eggs, oranges or grapefruit are served in skins or jackets. And cartons or small special stores of paper containers for their private use may be kept on hand to further reassure them.

Even where full food service is not on paper, the paper drinking cup at the bedside, paper cups of medicines, and nourishments served in paper, help to lessen dangers. Apart from the psychiatric advantages of paper at the bedside, is the nursing time saved. Not only does the patient require less watching, but the time-wasting handling of non-paper drinking utensils is eliminated.

"Wherever you have a potential suicide, you can't keep a glass at the bedside," the nursing director of a city hospital system points out. "The only safe thing is a paper cup. Otherwise the nurse must bring the patient a glass of water each time he drinks, then take the glass and wash and store it. When you multiply this service by numbers of patients, you have used a lot of time each day that might better go into nursing care."

In Neurological Institute of the Columbia-Presbyterian Medical Center in New York City, in the absence of the nurse, nothing breakable is left in the room of the disturbed patient. These patients are furnished with paper drinking cups. And all "mouth care trays" needing special oral hygiene, are equipped with paper containers to hold the oils, ointments and creams.

Integration of paper utensils into the psychotherapeutic program for restoring the mentally ill is typical of the modern attitudes toward mental therapy. As the strait-jacket, the houses of bedlam, and the old methods of force disappear, the newer treatment of fuller liberty for the mentally ill has taken their place.

(The above article is taken from "Single Service News" August-September, 1951)

* * * * *

INTERIM RECOMMENDATIONS FOR THE TREATMENT OF FLOUROACETATE POISONING

The selection of the best antidote for fluoracetate poisoning is complicated by the fact that there is little evidence of the effectiveness of any measure in man; experimental animals differ widely in their response to the poison. Also, some of the substances known to be effective, at least in experimental animals, are not generally available.

On the basis of existing information the following interim recommendations are made:

Lavage the stomach to remove the contents. This measure may still be of some value even several hours after the ingestion of the poison.

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Administer orally 4 cc./kg. of an equal mixture of 50 per cent ethyl alcohol (whiskey) and 5 per cent acetic acid (vinegar), or either one alone if both are not available. This may be repeated in 3 or 4 hours, if necessary, or smaller doses may be given at more frequent intervals.

If convulsions occur, administer intravenously with great care small doses of a short acting barbiturate. There is evidence that fluoroacetate potentiates the depressant action of barbiturates.

The intravenous administration of plasma may be of value. Large quantities should be avoided because of the danger of adversely affecting cardiac function. The recommended dose is 5 cc./kg of body weight.

If monoacetin (glyceryl monoacetate) is available it may be substituted for the alcohol and vinegar regime. This substance, if used, should be given intramuscularly although it is irritating by this route. The pharmacologic effects of this agent are not known completely, although its acute toxicity is undoubtedly low. The dose recommended on the basis of animal experiments is 0.25 cc./kg every hour. In view of its effectiveness in animals, the availability of monoacetin is desirable in installations where fluoroacetate is employed.

The value of monoacetin as an antidote is probably due to the generation from this compound of a utilizable acetate moiety. The administration of acetate per se, or as vinegar, provides a more direct, but as apparently less usable source of acetate. For this reason the co-administration of alcohol has been suggested to catalyze the oxidation of acetate. In addition, the alcohol is converted to acetate. Cardiac function is a prime consideration in fluoroacetate poisoning. Frequent electrocardiograms provide an important diagnostic and prognostic aid.

Arrangements have been completed for monoacetin to be stocked as an item of medical supply. Monoacetin will be requisitioned from Medical Supply sources by installation surgeons when they approve requisitions for Quartermaster Item, Rodenticide, sodium monofluoroacetate, Stock No. 51-R-475, forwarding both requisitions to the surgeon of the major command for approval.

(The above article is from SGO Circular No. 137, Dated 16 August 1951)

ADMINISTRATIVE SERVICE

ENLISTED PERSONNEL -- INAPTITUDE OR UNSUITABILITY

Quoted for information is Messageform dated 9 March 1951:

"There has been considerable indication recently that excessive numbers of submarginal and untrainable personnel have been accepted for service in the Army. This situation requires close and continued attention on the part of all persons charged with training and responsibility to insure the early detection of the individuals who are in fact inapt, untrainable, or unsuitable for military service. In this connection, it is imperative that the intent of paragraph 4, AR 615-369, be rigidly observed by all concerned. Evidence of inaptness, untrainability, or unsuitability may appear in repeated demonstrations of inability to absorb basic training, inability to follow simple instructions, uniformly low scores in aptitude areas, and so on. The best opportunity for detection of the inapt or untrainable individual exists during the basic training period. Accordingly, all company and similar unit commanders will, prior to or upon completion of the first six weeks of basic training, review the progress of each trainee and at that time recommend to the appropriate higher headquarters the initiation of proceedings under AR 615-369 for all personnel for whom they consider such action appropriate. Training divisions will retain personnel for whom proceedings under AR 615-369 have been recommended until such time as final disposition of the case has been made by the reviewing authority. Failure to take action on any individual on completion of the first six weeks of basic training will not preclude later action, should such action later appear to be appropriate."

(The above is from SGO Circular 138, dated 20 August 1951)

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LOW DEATH RATE OF ENEMY PRISONERS DUE TO ARMY MEDICAL SERVICE TREATMENT

Death among North Korean and Chinese Communist prisoners of war treated by the U. S. Army Medical Service at hospitals in Korea for battle wounds and injuries, over a six months period, have been only seven per cent, the Department of the Army announced today.

Approximately 37,000 enemy prisoners have been admitted as patients to Army hospitals in Korea.

Prompt medical attention given to POW patients by the U. S. Army Medical Service has resulted in the remarkably low death rates despite great complications present in a majority of the cases treated. The death rate among American wounded receiving medical attention in World War I was eight per cent.

While enemy strength has been depleted by the many diseases found among North Korean and Chinese Communist troops, and the apparent indifference of the enemy to caring for battle casualties, these conditions have placed unusual burdens on U. S. Army Medical personnel. During the six months period from September 1950 through early March 1951, for example, 797,316 outpatient treatments were given prisoners of war and vaccinations and immunizations were administered to 179,416.

In sharp contrast to the medical attention given United Nations troops and the common hygienic precautions taken by UN personnel is the lack of attention given to preventive medicine by the enemy.

"Judging by the high incidence of disease among captured Communist troops, the practice of preventive medicine is not being carried out effectively in their forces," according to Brigadier General James S. Simmons, U. S. A., retired, formerly Chief of the Preventive Medicine Division, Office of the Army Surgeon General and now Dean of Harvard University's School of Public Health. "Captured POW's have had an unduly high incidence of diseases, including leprosy, smallpox, typhus, typhoid, tetanus and other epidemic diseases."

The low and often non-existent standards of medical care provided by the enemy for their own casualties has also added to the U. S. Army Medical Service difficulties in Korea. Even at best, standards of treatment have been low in the Communist forces, with undergraduate medical students filling most medical officers' positions. Little or no provision has been made for drugs, equipment, or evacuation of casualties. Frequently, however, the enemy has shown utter indifference to the value of human life and wounded men are left to die, with no treatment of any kind. While the net result is a depletion of enemy forces, it creates highly complicated and involved cases for the Army.

"There was one big difference between UN troops and the enemy," a U.S. Army hospital staff member caring for POW's reported recently. "Allied soldiers received almost immediate care; the enemy wounded would not see a medical station until captured by UN forces."

Both because of enemy indoctrination and their own low standards of personal hygiene and sanitation, enemy prisoners have initially been difficult patients.

An Army nurse serving with the 117th Evacuation Hospital in Korea, Lieutenant Marie T. Genest of 8634 Dunbarton Road, Detroit, Michigan, has told of the reaction of POW's to treatment by American Army personnel.

"When we first received POW contingents, they were obviously racked with fear of us," she related. "When we picked up some of their stretcher cases for surgery, high piercing screams blasted our ears like bombs bursting on targets. Others would gaze at us from panic-ridden eyes, saying nothing but rigid with dread. Of what? That's where we were stumped and completely baffled.

"Here was an American hospital, prepared to give the same medical care to them that we were giving our own men. We were using the same medical and nursing skills for which the American armed forces are considered outstanding -- and yet these POW's were howling objections.

"In an attempt to get at the bottom of the uproar, a French missionary priest was asked to come and talk to the prisoners. Upon interrogation, he discovered that these North Koreans have been

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instructed that the Americans were vicious, sadistic people who would amputate their arms and legs just for practice."

Subsequent psychological warfare operations carried out by American troops in Korea have changed this attitude on the part of Chinese communist and North Korean soldiers. Leaflets and loud-speaker broadcasts have convinced them that they will be well treated if they surrender.

Pointing out that the U. S. Army Medical Service has conscientiously lived up to the Geneva Convention in caring for wounded sick prisoners of war, Major General George E. Armstrong, Army Surgeon General, said recently that all of the POW's have been given the same food, medical care and sanitary conditions as that received by UN troops.

"To neglect or mistreat prisoners of war would reduce us to the ethical level of the enemy," General Armstrong said, "and in the end the prestige of our country and of the other United Nations would inevitably suffer in the eyes of history. The International Red Cross has sent representatives to our prisoner of war hospitals who have, without exception, praised enthusiastically what we are doing for such prisoners. This is in contrast to the enemy's refusal to permit representatives of the International Red Cross so much as to enter the North Korean area."

(The above article is from Office of the Surgeon General, Technical Information Office, Department of the Army, Washington 25, D. C.).

* * * * *

ARMY MEDICAL PERSONNEL WIN OUTSTANDING NUMBER OF DECORATIONS IN KOREA

A preliminary survey reveals that over 2,800 decorations have already been awarded to Army Medical Service personnel for service in the Korean campaign.

The total includes a posthumous award of the Medal of Honor to Private Richard C. Wilson, aid man with the 187th Airborne Infantry Regiment; nine Distinguished Service Crosses; two Distinguished Service Medals; 149 Silver Stars; 28 Legion of Merit awards; 2 Distinguished Flying Crosses; eleven Soldier's Medals; 1,369 Bronze Star Medals; nine Air Medals; 126 Commendation Ribbons and 1,110 Purple Hearts.

Eighty-five percent of the decorations were awarded to Army Medical Service enlisted men. In addition to the Medal of Honor these included eight Distinguished Service Crosses; 122 Silver Stars; eight Soldier's Medals; 1,080 Bronze Star Medals; 103 Commendation Ribbons; and 1068 Purple Hearts.

Medical Service Corps officers serving as assistant battalion surgeons, administrators, supply officers, or in similar capacities, received almost ten percent of the total, including 20 Silver Stars, seven Legion of Merit awards; two Distinguished Flying Crosses; three Soldier's Medals; 192 Bronze Stars; one Air Medal; eleven Commendation Ribbons and 36 Purple Hearts.

Medical Corps officers received 105 decorations, including one Distinguished Service Cross; two Distinguished Service Medals; seven Silver Stars; 18 Legion of Merit awards; 59 Bronze Star medals; eight Air Medals; six Commendation Ribbons and four Purple Hearts.

Sixteen dental officers were decorated. Awards included one Legion of Merit; 11 Bronze Star medals; two Commendation Ribbons and two Purple Hearts. One Veterinary officer received the Bronze Star.

Awards to the women's corps of the Army Medical Service totalled 32, including two Legions of Merit; 26 Bronze Stars and three Commendation Ribbons to Army Nurse Corps officers, and one Commendation Ribbon to an officer of the Women's Medical Specialist Corps.

(The above article is from Office of the Surgeon General, Department of the Army, Technical Information Office, Washington, D. C., dated 28 August 1951)

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PREVENTIVE MEDICINE

THE COLD FACTS . . .

Some of the most common questions about home refrigerators and cold storage units, are answered by Mr. Carl S. Ferguson, Director of the Division of Food and Drugs.

Which foods should be placed in the coldest part of the refrigerator which is usually next to the refrigeration unit?

Those which deteriorate the most rapidly, for example, milk and uncooked meats.

Is there any reason why food, still hot from cooking, should not be put in the refrigerator until it has cooled?

This depends upon the type of food being stored. Hot liquids, for example ordinarily are not harmed by being stored before cooling, but they do tend to raise the temperature of the refrigerator. In freshly cooked meat, if a warm portion in the center is thus sealed inside the meat; decomposition may result.

Should meat be stored covered or uncovered? Should paper wrappings be removed from raw meat?

Fresh meat should be stored uncovered or loosely covered and papers should be removed, since paper coverings act as insulators and prevent free circulation of air around the meat. The free circulation of cold air assists in keeping all portions of the meat at a lower temperature and thus aids in retarding bacterial growth which leads to decomposition. Cooked meat should be stored closely covered to prevent drying. Since cooked meats contain fewer numbers of bacteria than uncooked meats, decomposition is not likely to occur so rapidly.

Should other cooked foods be stored covered or uncovered?

There is no significant relationship between covering of cooked foods and spoilage. The main reasons for covering cooked foods are to prevent the absorption of ice box odors, drying out, escape of desirable flavors, or the imparting of objectionable odors to other foods.

Is it safe to leave food in the refrigerator in metal containers once they have been opened?

Although many authorities feel that there is no evidence that this practice is harmful, it is safer to remove from the can any food which is not to be used within a day or two. There is some possibility that protein foods in particular, such as meat and fish, might become more susceptible to contamination if left too long in the container.

How should milk be stored?

Milk should be stored in the coldest part of the refrigerator since it is highly perishable. Clean pasteurized milk stored in this way should keep for about a week without decomposition, although it may become "sour" within a shorter period. It is most important to prevent contamination of the milk from contact with germs from the respiratory tract. For this reason milk left in someone's glass should never be returned to the bottle in the refrigerator.

Can melted ice cream safely be refrozen?

This is usually not advisable. It will not ordinarily return to the same consistency since melting may result in separation of the constituents. There is also the possibility of bacterial growth while it is melted.

Should filling for eclairs, cream puffs and similar pastries be kept in the refrigerator?

Just as bakeries must keep such filling under refrigeration at all times and must use the filling in the product on the same day as it is prepared these same rules should be followed at home for the safety of the family.

Is it safe to use ice cubes which have been left frozen in a tray for a long period?

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Although this is usually not physically harmful, it is not good practice since ice cubes tend to absorb odors and may also be subject to some mold growth. Ice cube trays should be emptied often enough to prevent this, that is, at least every two weeks.

At what temperature should a refrigerator be kept?

It is advisable to keep a refrigerator at 34° to 40° F. since bacterial growth is retarded at this temperature. If the temperature is allowed to rise 50° to 60° F. there will be marked increase in bacterial growth.

What temperature is recommended for a home freezer?

In cold storage warehouses the temperature is normally below 0° F. In the home freezer it should be kept at least below 20° F.

Why should food be cooled before it is "quick frozen"?

If food is not allowed to cool first, heat may be sealed inside with resulting decomposition.

What is the best way to thaw large products such as fowl?

Because of the danger arising from possible contamination either prior to freezing or during the thawing process such products should not be thawed by leaving them at room temperature for a long period. Instead it is better to allow them to thaw in the refrigerator, outside the freezing compartment.

Does it make any difference how often you defrost and clean your refrigerator from a standpoint of food preservation?

A unit heavily coated with ice is less efficient as a source of cold, making it more difficult to maintain a sufficiently low temperature. The frequency with which defrosting is necessary depends of course on the accumulation of ice, but a refrigerator which is not defrosted and cleaned at least every two or three weeks is not likely to be sufficient.

Is there any objection to covering refrigerator shelves with paper?

One of the basic principles of refrigeration is that heat is removed from food through circulation of cold air. Placing papers on refrigerator shelves is objectionable because it interferes with this air movement.

Should any special precautions be taken in storing salads in a refrigerator?

If salad is prepared from warm ingredients, the center of the salad remains warm for a long period, even in a refrigerator. Dead air spaces, which are found particularly in 'lumpy' salads, also slow down the cooling process. Salads easily become contaminated with harmful organisms, and under warm temperature conditions these may multiply to a dangerous extent. To prevent this, salad ingredients should be chilled thoroughly before the salad is prepared by being placed in shallow containers in the refrigerator. These should not be allowed to become warm after removal from the refrigerator, and after the salad is prepared, it too should be stored in shallow pans in the refrigerator.

(The above is extracted from Massachusetts Department of Public Health "News Letter" Vol XX, Nov 1949, No. 3)

Sanitation is a way of life. It is the quality of living that is expressed in the clean home, the clean farm, the clean business and industry, the clean neighborhood, the clean community. Being a way of life it must come from within the people; it is nourished by knowledge and grows as an obligation and an ideal in human relations.

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PREVENTIVE MEDICINE

THE EFFECTS OF NOISE ON MAN

The July Medical Information Letter featured an item on the subject of noise hazards. The previous article cited the results of a noise level survey of an AF base, and extracts of an editorial on noise problems from the American Journal of Public Health and the Nation's Health. A monograph by Karl D. Dryter, supplementing The Journal of Speech and Hearing Disorders, "The Effects of Noise on Man," comes to attention this month. The interesting general conclusions drawn by the author are extracted as follows.

A survey of the literature pertaining to the effects of noise on mental and motor work in industry and in the laboratory situation and to related studies concerning annoyance and physiological reactions to noise has been made. This survey shows that nearly all industrial and laboratory experiments which report that noise adversely affects work output are open to criticism because of poor experimentation and uncontrolled factors. (by "work" is meant any mental and motor tasks not involving communication by speech.) On the other hand, experiments carried out with proper control of all pertinent factors reveal that steady or expected noises do not adversely affect psychomotor activity to any significant extent. As a matter of fact, there is some evidence that noise may "insulate" a person from intermittent distractions in this environment so that on some tasks, such as aiming a gun, performance is better in noise than in quiet.

The general ineffectiveness of noise on work output and on psychomotor performance can be largely explained by a psychological and physiological adaptation and perhaps by an increase in effort on the part of the subjects. About 50% of subjects exposed for long periods to intense, and particularly to high-frequency noise, feel that exposure to such noises makes them more irritable than normal. Some comfort is gained by preventing steady noises from exceeding 90 db at the position of the listener. Most persons exposed to intense noise as high as 120 db as a matter of course in their work apparently become indifferent to it. Mention is made of certain effects of noise when its level is as high as 150 db.

Although steady-state noises appear to have little real effect on work output, it will have an adverse effect upon communication by speech or other auditory signals, and it has been experimentally demonstrated that the "annoyance value" of a noise is related to its spectrum. Noises containing the higher frequencies of sound are more annoying than those of predominately low frequencies.

Probably most of the experiments conducted on this problem did not reflect the full impact of noise on the performance of the office and industrial worker in that the studies were primarily confined to non-auditory work not involving communication, whereas communication is required in most occupations. Thus, noise absorption and reduction should lead to greater efficiency and comfort of the office and industrial worker, although most of the experimental results so far have been negative or inconclusive.

The study of the experimental literature on the effects of noise on the auditory mechanism reveals the following points:

(1) Exposure to intense noise from machinery causes partial and temporary hearing losses that persist for a few minutes to several hours. Apparently, continued repeated exposures over extended periods (years) may result in a partial but permanent deafness. The more intense the sound the greater the deafening effort. The maximum safe intensity at which no deafening effect will occur is probably in the neighborhood of 85db for "critical band" of noise. The over-all intensity of a noise in decibels usually will not correctly indicate its deafening effect.

(2) Both field and laboratory tests indicate that deafness occurs for the dominant frequency in a noise and/or for higher frequencies.

(3) Exposure to gun fire and other shock or blast waves results in a partial deafness that lasts for a few minutes up to several days, and continued repeated exposure results in a partial but permanent deafness that may be progressive with continued exposure.

(4) Rupture of the eardrum may be caused by blast waves or by extreme and rapid pressure changes resulting from rapid changes in altitude such as may occur in military flying and submarine

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activity. Deafness resulting from such insult is apparently due to secondary effects occurring in the middle ear such as infection, the development of fluids and exudates, and the rearrangement of middle ear structures in addition to possible direct damage to the cochlear structure.

Earplugs which afford 20 to 30 db of sound attenuation for the middle range of frequencies will in practically all present industrial and military situations where noises and shock waves are a problem afford sufficient protection from the noise to prevent deafness. The wearing of proper earplugs in intense noise fields improves speech communication as well as giving comfort and protection.

Earplugs individually molded and fitted to each person would probably be the most comfortable and adequate method of protecting an individual from high levels of noise. There are certain earplugs now manufactured which provide good sound attenuation but not all people can wear them with comfort. Dry cotton, which has been used extensively by military personnel, does not afford much protection against the low and middle range of sound frequencies although it does reduce to some extent the intensity of high frequencies which subjectively are the most annoying.

Probably the most deleterious effect that noise has on man's behavior is the disruption or "masking" of speech communication. It would be desirable to be able to engineer, on the basis of physical measures, electronic communication systems that would provide satisfactory intelligibility of speech in the presence of intense noise. A method has been derived whereby an "Articulation Index" or "Speech Intelligibility Index" can be computed from careful physical measures of the signal coming from any particular communication system and of the noise in which that system is operated.

In general, noise will have little effect on the intelligibility of speech provided the long average intensity of speech is 18 db more intense than the noise throughout the frequency range from 200 to 7000 cps. The "Articulation Index" is valid, however, only with certain types of noise. Also, in its computation, such significant factors as amplitude distortion, interaural phase relations, reverberation, and others, are not taken into account.

(The above article is from MATS Medical Information Letter, dated 25 August 1951)

* * *

ARMY TO USE NEW FOOT POWDER TO PREVENT COLD INJURIES

Army medical research has developed a new foot powder that reduces foot perspiration, offering partial protection against cold injuries to troops living or fighting in cold weather areas.

Arctic tests have shown that the foot powder reduces sweating by as much as 24 percent. This development is of major importance to troops in a cold environment because cold injury more frequently involves the feet than any other extremity. Trenchfoot develops in "wet cold" whereas frostbite is associated with "dry cold."

Man's feet perspire under almost all conditions but the secretion of the sweat glands is especially harmful in cold weather because crystallized particles of perspiration act as conductors of cold, thereby diminishing the insulative value of winter footwear. By reducing foot sweating, the new powder will make the winter soldier's heavy socks and boots more effective against cold injury.

The new preparation has a powdered talc base and contains aluminum chloride and potassium alum, the anhidrotic agents as well as boric acid, salicylic acid and starch.

The initial shipment of the powder will be delivered to the Army this fall and will be issued to troops assigned in cold weather areas including those in Korea. The powder will be packaged in seven separate envelopes contained in one heat-sealed cellulose kit. This is a soldier's one-week supply. Troops will be instructed in its use.

(The above article is from Office of the Surgeon General, D/A, Technical Information Office, Wash, DC)

PREVENTIVE MEDICINE

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GENERAL COMMENT

The health of the command continued to be excellent.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and Class II installations, exclusive of Walter Reed Army Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army Medical Service installations do not include Air Force personnel. (See General Data and Admissions Tables on page 15).

The non-effective rate* increased from the July rate of 12.89 to 14.68 for the month of August. Days lost as a result of disease and injury totaled 15,111 during the five week period ending 29 August 1951.

*Non-Effective Rate -- $\frac{\text{Total Days lost} \times 1,000}{\text{No. of Days in Period} \times \text{Average Daily Strength}}$

Non-Effective rates indicate the average number of patients in hospital or quarters per thousand mean strength during the report period.

The total admission rate** for disease and injury in August was 386.7, compared to 320.1 during July. Total admissions for disease and injury in August was 1091. Of this number 908 admissions were for disease and 183 injuries. Fort McNair reported the highest admission rate, and All Others reported the lowest rate during the current month.

**Admission Rates -- $\frac{1,000 \times 365 \times \text{Number of Cases}}{\text{Mean Strength} \times \text{No. of Days in Period}}$

Admission rates show the number of cases per thousand strength that would occur during a year if cases occurred throughout the year at the same rate as in the report period.

August's rate for disease cases is 321.8 for 908 cases. Fort McNair reported the highest admission rate, and All Others reported the lowest rate for disease cases.

An injury admission rate of 64.8 per 1,000 per annum for August was reported. This was an increase over the July rate of 57.6. Fort Belvoir reported the highest rate and All Others reported the lowest rate for injuries.

There were no deaths reported during the five week period ending 29 August 1951, by units within the Military District of Washington less Walter Reed Army Hospital.

COMMUNICABLE DISEASE

Common respiratory diseases increased in incidence during the month of August 1951. The rate for the present month is 90.7 compared to the July rate of 47.8. The U. S. Army Dispensary, The Pentagon reported the highest rate, and All Others reported the lowest rate. Admission rates for pneumonia (all types) decreased during the August report period. The rate being 3.9 compared with the July rate of 16.5. There were no cases of scarlet fever reported throughout the month of August.

No appreciable change was noted in the rate for mumps, tuberculosis, rheumatic fever, and hepatitis during the five week period ending 29 August 1951.

Pertinent statistical tables may be found on pages 16 and 20.

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GENERAL DATA

5-Week Period Ending 29 August 1951
(Data from DD Forms 442)

(Data from DD FORMS 442)

STATION	MEAN STRENGTH			DIRECT ADMISSIONS						Non-Effective Rate	Number of Deaths
	Total	White	Negro	All Causes		Disease		Injuries			
				Cases	Rates	Cases	Rates	Cases	Rates		
Fort Belvoir, Virginia	17737	15752	1985	682	400.96	547	321.59	135	79.37	14.63	0
Fort McNair, Wash, D.C.	871	799	72	48	574.68	44	526.79	4	47.89	10.86	0
For Myer, Virginia	4074	3923	151	190	486.33	162	414.66	28	71.67	11.45	0
U.S. Army Dispensary The Pentagon	3948	3939	9	113	298.47	99	261.49	14	36.98	23.54	0
All Others	2787	2781	6	58	217.02	56	209.53	2	7.48	8.33	0
Total - Military Dist. of Washington	29417	27194	2223	1091	386.75	908	321.88	183	64.87	14.68	0
AMC - Med Det(Duty Pers)	1601	1465	136	77	501.50	71	462.40	6	39.10	23.20	7

ADMISSION, SPECIFIED DISEASES - RATE PER 1000 PER YEAR

5-Week Period Ending 29 August 1951
(Data from DD Forms 442)

STATION	Common Respiratory Diseases	Pneumonia All Types	Pneumonia Atypical	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Hepatitis	Malaria	Influenza	Psychiatric Disease
Fort Belvoir, Va.	87.60	5.83	2.94	1.76	2.94	-	-	-	1.16	1.76	-	8.25
Fort McNair, Wash, DC	83.81	-	-	-	-	-	-	-	-	47.89	-	-
Fort Myer, Virginia	102.39	-	-	-	-	-	2.56	-	-	5.12	-	18.80
US Army Dispensary The Pentagon	118.86	2.64	2.64	-	5.28	-	-	-	2.64	2.64	-	2.64
All Others	56.12	-	-	-	3.74	-	-	-	-	-	-	3.74
Total-Military Dist. of Washington	90.75	3.90	2.13	1.06	2.84	-	.35	-	1.06	.354	-	7.44
AMC-Medical Detach. (Duty Pers)	110.70	-	-	-	-	-	-	-	-	-	-	-

At this time of year we must recognize the importance of instituting adequate measures for the prevention and control of respiratory diseases. These diseases are among the most important of the communicable diseases occurring in the Army from the aspect of man-days lost. Preventive measures begun now will pay off in reduced incidence of disease during the inclement weather ahead.

VENEREAL DISEASE EPIDEMIOLOGIC REPORT

A recent analysis of PHS Forms 1421 (VD) shows a marked improvement in the information furnished thereon. However, too many contact reports are still being returned from civilian health authorities marked "insufficient information to locate". It is incumbent on all medical officers responsible for the treatment of venereal disease patients to establish a proper patient-doctor relationship in order that adequate information may be obtained to seek out and eliminate infected contacts.

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RESTRICTED**PREVENTIVE MEDICINE****VENEREAL DISEASE**

Venereal Disease rate among units within the Military District of Washington, decreased during the August report period.

The rate for August 1951, was 16.31, a decrease from the July rate of 21.01. A total of 46 cases were reported for the five week period ending 29 August 1951. Of this total 42 were reported by Fort Belvoir, 2 cases for Fort Myer and 2 cases for Fort McNair.

During the report period, white personnel incurred 16 of the reported number of cases, with a rate of 6.14 and 30 were incurred by Negro personnel with a resulting rate of 140.73 per 1000 troops per annum.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken to report the number of cases per 1000 men for this report period (August) in addition to the rate per 1000 per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 17 and 18.

NEW VENEREAL DISEASE CASES - EXCL EPTS - JUNE, JULY AND AUGUST 1951

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	JUNE 1951	JULY 1951	AUGUST 1951	AUGUST 1951
Fort Belvoir	22.84	33.41	24.69	2.367
Fort McNair	32.07	-	23.94	2.296
Fort Myer	15.43	6.14	5.12	.490
U.S. Army Dispensary, Pentagon	-	-	-	-
All Others	-	5.06	-	-
Total - Military District of Washington Units	16.58	21.01	16.31	1.563
Army Medical Center - Medical and Holding Detachments	4.14	11.69	25.66	2.460
Total - Dept/Army Units Military Dist/Wash	15.33	20.05	17.24	1.652

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"Morally, and fundamentally, the free world has the undeniable power of a better idea. In our way of life, no worship is denied, no abandonment of religion is required, no elections are counterfeited, no automatic "yes" is demanded."

General of the Army Omar N. Bradley

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CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY
MDW RATE PER 1000 TROOPS PER YEAR

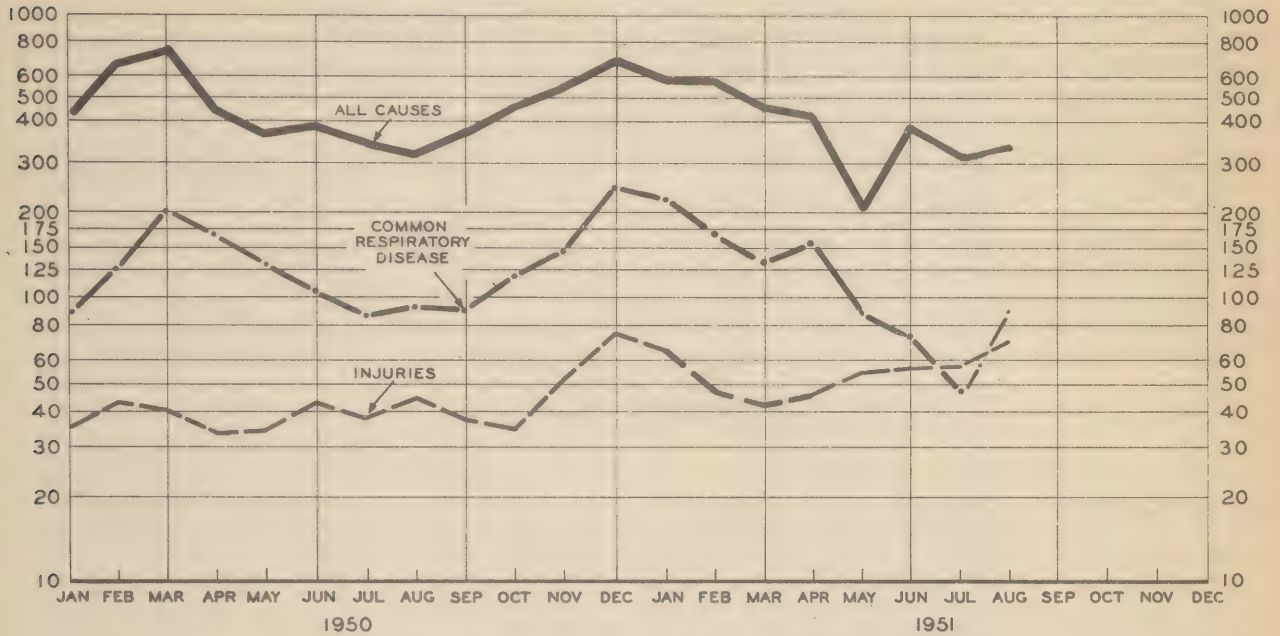
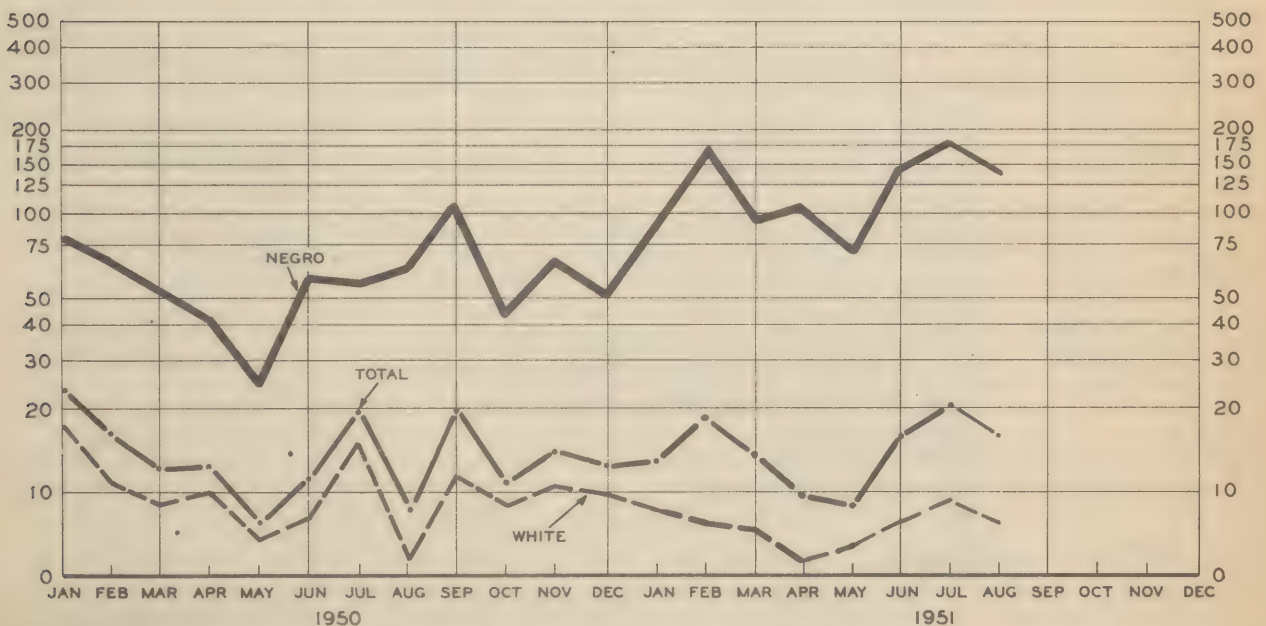


CHART 2

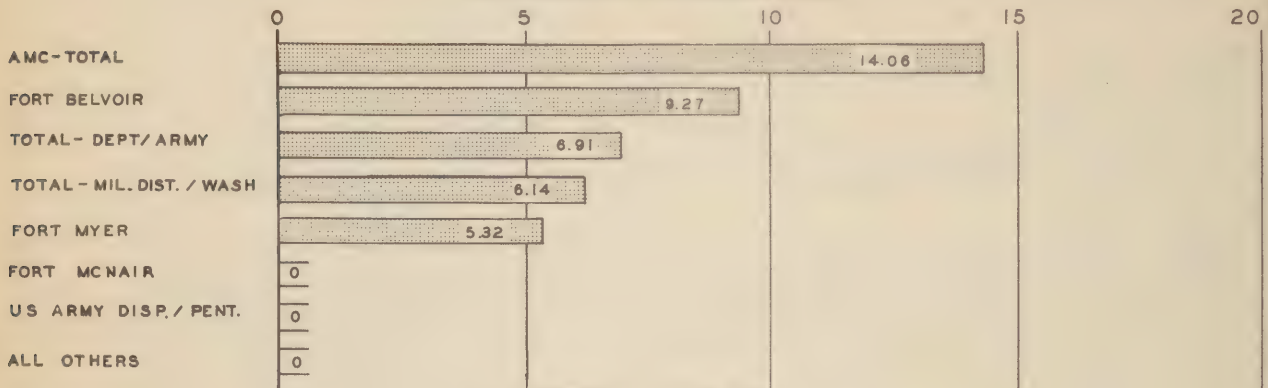
ADMISSION RATES BY MONTH VENEREAL DISEASES MDW NOT INCL. ARMY MEDICAL CENTER
RATES PER 1000 TROOPS PER YEAR
INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS



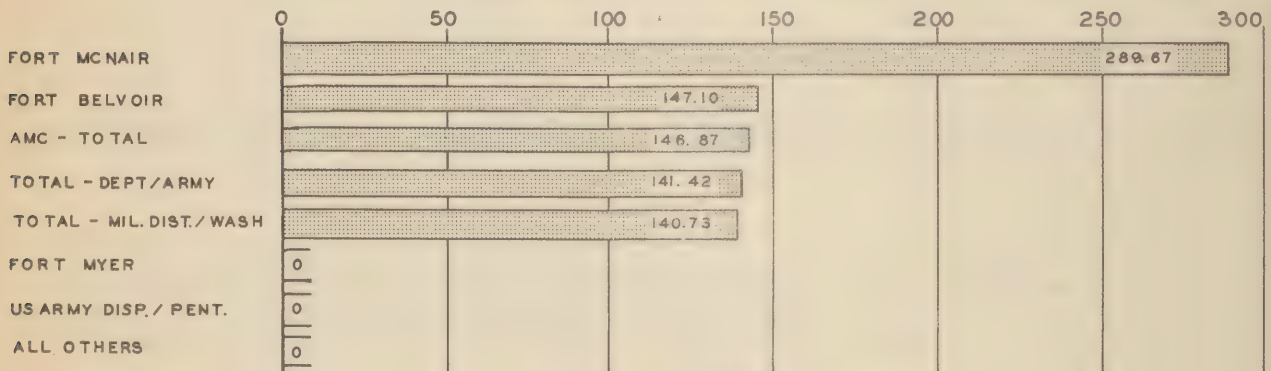
PREVENTIVE MEDICINE

RESTRICTED

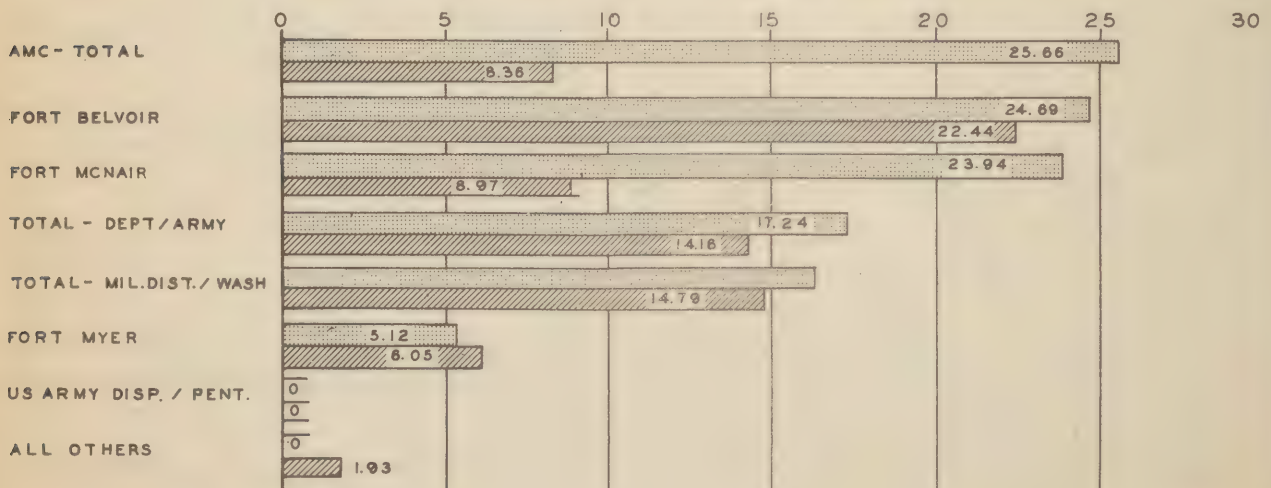
VENEREAL DISEASE
RATE PER 1000 TROOPS PER YEAR
5 WEEK PERIOD ENDING 29 AUG 1951
WHITE PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE
RATE PER 1000 TROOPS PER YEAR
5 WEEK PERIOD ENDING 29 AUG 1951
NEGRO PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE
RATES PER 1000 PER YEAR
FIVE WEEK & CUMULATIVE TOTALS ENDING 29 AUG 1951
TOTAL WHITE & NEGRO PERSONNEL (CHARGEABLE CASES)



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PREVENTIVE MEDICINE

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CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT For the Five Week Period Ending 29 August 1951 (Data from DD Form 442) (Chargeable Cases)

STATION	R A C E	Mean Strength	Syphilis	Gonorrhea	Other	Total	Rates per 1000 Troops per Annum
Fort Belvoir	W	15752	3	11	0	14	9.27
	N	1985	8	19	1	28	147.10
	T	17737	11	30	1	42	24.69
Fort McNair	W	799	0	0	0	0	-
	N	72	2	0	0	2	289.67
	T	871	2	0	0	2	23.94
Fort Myer	W	3923	2	0	0	2	5.32
	N	151	0	0	0	0	-
	T	4074	2	0	0	2	5.12
US Army Dispensary The Pentagon	W	3939	0	0	0	0	-
	N	9	0	0	0	0	-
	T	3948	0	0	0	0	-
All Others	W	2781	0	0	0	0	-
	N	6	0	0	0	0	-
	T	2787	0	0	0	0	-
Total-Military District of Washington	W	27194	5	11	0	16	6.14
	N	2223	10	19	1	30	140.73
	T	29417	15	30	1	46	16.31
Army Medical Center	W	2967	4	0	0	4	14.06
	N	284	0	4	0	4	146.87
	T	3251	4	4	0	8	25.66
Total-Dept/Army Units	W	30161	9	11	0	20	6.91
	N	2507	10	23	1	34	141.42
	T	32668	19	34	1	54	17.24

VENEREAL DISEASE RATES* (All Army Troops)

	JUNE	JULY	AUGUST
First Army Area	21	31	39
Second Army Area	22	28	27
Military District of Washington	16	20	17
Third Army Area	30	32	26
Fourth Army Area	48	39	35
Fifth Army Area	19	24	28
Sixth Army Area	30	41	40
TOTAL United States	28	32	31

*Compiled in the Office of the Surgeon General and Includes US Army Hospitals

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DENTAL SERVICE

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DENTAL SERVICE - FIVE WEEK PERIOD ENDING 29 AUGUST 1951

STATION	Military		Civilian		Sit- tings	Amal- gam	Oxy and Amal	Sili- cate	In- lays	Bridges	Bridge Repair	Crowns	Dentures		Re- pair	Ex- trac- tions	Calcu- lus	Ex- trac- tions	Ex- trac- tions
	Men	Duty Days	Men	Duty Days									Full	Par- tial					
Fort Belvoir	19	831	1	22	9470	3107	1696	665	5	25	29	35	37	78	26	1728	497	2923	1305
Fort McNair	2	55	0	0	458	108	127	25	1	2	1	2	3	12	1	43	17	41	206
Fort Myer, Va.	4	112	1	21	1889	477	106	110	3	6	8	4	9	22	11	144	77	667	462
US Army, Dispen- sary, Pent.	8	225	0	0	2163	559	239	199	6	5	11	8	10	19	20	172	141	1128	762
All Others	4	88	0	0	1269	235	131	80	5	5	0	5	14	41	2	255	57	120	764
Total - MDW	47	1311	2	43	15249	4486	2299	1079	20	43	49	54	73	162	60	2350	27	4902	4019

VETERINARY SERVICE

POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED AUGUST 1951 (Data obtained from WD AGO Forms 8-134)

STATION	CLASS* 3	CLASS* 4	CLASS* 5	CLASS* 6	CLASS* 7	CLASS* 8	CLASS* 9	TOTAL
Fort Lesley J. McNair		58,059	159,788		213,385		57,495	488,727
Fort Belvoir, Virginia		522,949	523,793		1,034,756	172,920	448,816	2,703,234
Alexandria Field Buying Office		612,624	143,890	764,292			96,313	1,617,119
Fort Myer, Virginia		133,057	198,758		337,338	8,118	168,937	846,208
Cameron Station, Virginia		127,249	158,935		310,890	7,281	66,230	650,585
MDW Veterinary Detachment	951,386							951,386
The Pentagon						338,686		338,686
Army Medical Center		208,355	159,230		383,720	15,082	56,874	823,261
TOTAL	951,386	1,662,293	1,324,394	764,292	2,280,089	542,087	894,665	8,419,206

REJECTIONS:

Not type class of grade								
MDW Vet Det	15,145							15,145
The Pentagon						198		198
Insanitary or Unsound								
Alexandria FBO		1,341						1,341
MDW Vet Det	8,040							8,040
TOTALS	23,185	1,341				198		24,724

*Class 3 - Prior to Purchase
 *Class 4 - On delivery at Purchase
 *Class 5 - Army Receipt except Purchase
 *Class 6 - Prior to Shipment

*Class 7 - At Issue
 *Class 8 - Purchase by Post Exchange, Clubs,
 Messes or Post Restaurants
 *Class 9 - Storage

OUTPATIENT SERVICE

OUTPATIENT SERVICE

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital, are indicated below for the five week period ending 29 August 1951:

ARMY:

Number of Outpatients 15974
 Number of Treatments 19907
 NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED 1551
 NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED 9633

NON-ARMY:

Number of Outpatients 20398
 Number of Treatments 22779
 NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED 1551
 NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED 9633

HOSPITAL MESS ADMINISTRATION

HOSPITAL MESS ADMINISTRATION

STATION

	MAY 1951	JUNE 1951	JULY 1951	AUGUST 1951
Fort Belvoir				
Income per Ration	\$1.2996	\$1.3178	\$1.3327	\$1.3456
Expense per Ration	1.2549	1.2453	1.2586	1.2556
Gain or Loss	+0.0447	+0.0725	+0.0741	0.0900

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CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM

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WORLD MEDICINE AND INDUSTRY

Industrial medical progress is a subject of vital interest to the employee, the physician and the community. At the moment we stand on the threshold of a new era where the machine age is helping rather than hindering mankind in his search for health. Heretofore the conflict of man and machine has been such that accident, illness and sudden death have been accepted as necessary for progress. Now, thanks to the present interest in the field of human relations in industry, leading universities are conducting research programs, supported by both labor and business, in order to improve the health of the worker. Top executives and experts in scientific management and medical, public and employee relations are holding frequent meetings on various phases of the subject.

The health of our employed population is important if the human resources of the country are to be fully utilized for efficient production and full employment.

Progressive management no longer confines its activities to the engineering sciences, fundamentals of sanitation and public health, lighting, temperature, ventilation and physical safety when considering industrial health. More and more interest, time, and money are given to the social sciences, in which realm the physician's knowledge, experience and appreciation are outstanding. Nevertheless, to date, the physician has failed to impress the public at large with the unique capabilities in the field of social science.

We are all conscious of much unsound medical legislation, the result of great public fear when epidemics spread over our country many years ago. Today, with our country preparing itself for war emergency, there is a similar public fear leading to demands for medical legislation. Can medical legislation of any kind be effective unless the ideals of our profession are correctly and earnestly promulgated?

With the appreciation of this fact it behooves the various men of our profession--the internist, the surgeon, the ophthalmologist, the neuropsychiatrist, the physician in industry, and the general practitioner--to understand the meaning of teamwork and human relations. The whole fabric of any community--all the political, social and economic bonds that hold its various segments together--depends upon individuals having jobs and opportunities to make a living.

Human relations on the job are complicated, as in other aspects of living. At other times and places a person is left largely to his own devices, but at work he has to adjust himself not only to the job itself and its physical environment but also to his supervisors, other people around him, and the rules and regulations of the organization.

There is abundant evidence that many workers are not adjusting themselves properly. Many such people are not well. Naturally, the question arises as to the best method of determining the exact nature of their illnesses. It cannot be assumed that a person is perfectly well when he shows up for work in the morning; likewise, it cannot be taken for granted that he is ill when he stays away. Such thoughts bear directly upon the question of absenteeism.

Unfortunately, perhaps, the average practicing physician confines his interest to the immediate problem of the patient. He readily detects physical defects, but time alone often prevents him from evaluating the patient's entire personality--the combination of his traits, reactions to other persons, to strain and stress, and his particular emotional make-up pattern--in other words, his entire physical, mental and social state.

The importance of a pre-placement physical examination is well recognized. The temperament of an individual and the environment in which he is to be placed are exceedingly important. In order to evaluate the individual properly, the examining doctor reviews the past history and obtains all pertinent details regarding disease, injuries and operations. It is evident that this data should be complete, particularly if a history of epilepsy, insanity, diabetes, malignancy, pulmonary tuberculosis, or other serious disorders is to be elicited. The more competent the examiner, the more valuable the records. This is of great importance later when periodic health inventories are taken; unfavorable changes can be easily noted and the necessary steps of constructive medicine applied to maintain the maximum health of the individual.

(The above article is By: Robert Collier Page, MD., Associate Clinical Professor of Industrial Medicine New York Univ. Post-Grad. Med. Sch., which was published in Industrial Medicine & Surgery, Sep. 1951)

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